Rehabilitation Aspects of Human Sexuality

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The PLISSIT model is a comprehensive program that combines educational strategies with behavioral intervention to integrate human sexuality into the initial rehabilitation of spinal cord-injured persons. Sexuality is treated as a health care issue as important as bowel and bladder care, skin care, psychosocial issues, mobility, self-care and vocational concerns. Patients admitted to the Spinal Cord Injury Program are surrounded by a supportive milieu and an interdisciplinary staff who comfortably incorporate sexuality into discussions about catheter care, positioning, communication styles, assistive devices and so forth. Patients are exposed to a behavioral training program that makes available didactic lectures, group and individual sessions, bibliotherapy, films and opportunities for directed overnight sexual exploration within the hospital. We advocate that sex therapy be integrated into comprehensive rehabilitation programs along with physical therapy, occupational therapy, recreation therapy and psychotherapy as an integral and effective form of functional restoration for patients with major physical disabilities.

The blossoming of effective techniques for treating sexual dysfunctions in healthy persons[1,2] can have tremendous impact on the management of spinal cord-injured patients. At Casa Colina Hospital for Rehabilitative Medicine an organized program of sexual rehabilitation has been developed for recently disabled persons. Modern sex education, counseling and therapy techniques have been systematically integrated into the initial comprehensive rehabilitation plan for newly paraplegic and quadriplegic persons.

Statement of Beliefs

We believe, first, that sexual functioning is a legitimate and important concern in a comprehensive rehabilitation program. Second, as in the areas of atrophy, contractures and decubitus, early intervention maximizes function and minimizes secondary complications. Third, the PLISSIT model of sex therapy (described in the following section) provides the opportunity for involvement of all staff and patients according to their interest and level of comfort.

Treatment Model

The PLISSIT model[3,4] is based on a vertical structure of emphasis in sex therapy beginning with *P*ermission and proceeding through *L*imited *I*nformation, *S*pecific *S*uggestions and *I*ntensive *T*herapy (see Figure 1). The model is both flexible and comprehensive and provides a framework for differentiating those problems amenable to brief treatment approaches from others requiring intensive therapy.

Permission

We have found that permission is most effective when it is consistently reflected by authority figures, treatment staff and peers. The topic of sexuality is introduced by a physician within hours of a patient's admission to the rehabilitation center while taking an overall medical history and doing a physical examination. The nature of current intimate relationships is assessed, premorbid sexual patterns are reviewed and a history obtained regarding the patient's awareness of sexual feelings, erection, ejaculation and orgasm since the acute injury. The genitalia, sacral sensation, voluntary rectal control and the sacral reflex arc are examined. The relationship of these findings to sexual potential is explained and the patient is given suggestions to further explore and become aware of his or her newly changed body. The patient is oriented to the presence within the hospital of the Activities of Daily Living Apartment, which provides an opportunity for privacy and for sexual exploration. Thus permission is granted by the physician for sexuality to be a very matter-of-fact and routine aspect of the rehabilitation process.

Because the total treatment milieu represents a vital force in shaping patients' acceptance and risk taking,

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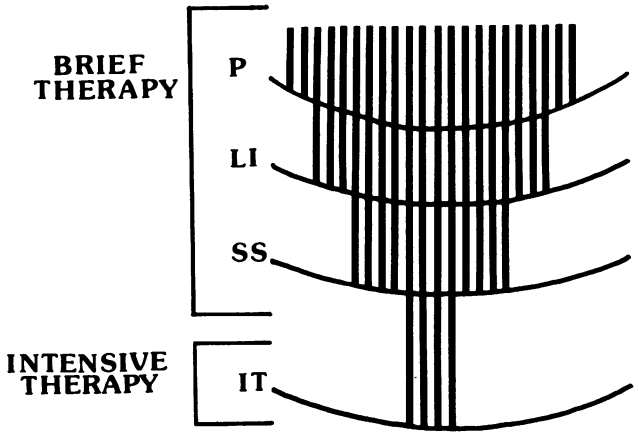

Figure 1.—The PLISSIT model provides four levels of approach to the treatment of sexual concerns: Permission (P), Limited Information (LI), Specific Suggestions (SS) and Intensive Therapy (IT). The first three levels can be viewed as brief therapy, the fourth level as intensive therapy. Most sexual concerns can be treated with the briefer approaches (adapted from Annon[3]).

all members of the staff are encouraged to reflect permission and to be tolerant and supportive of the expression of concerns related to sexuality. All staff members have been encouraged to explore their own attitudes and personal comfort levels by participating in a Disability Sexual Attitude Reassessment Workshop.[5] It is recognized that staff members, patients, spouses and "significant others" vary in their openness, interest and degree of concern about sexuality. We therefore strive for an approach that is sensitive to the range of individual needs and values.

Limited Information

In addition to a commitment to permit dealing with sexual issues, interested members of all team disciplines are developing an expertise as educators in sexual functioning as it relates to their own area of responsibility. For example, a physical therapist might discuss and teach aspects of bed mobility and positioning as it relates to sexual activity; an occupational therapist might extend alternate ways of functioning and the use of adaptive equipment to the sexual sphere, and members of nursing staff teach coping skills related to involuntary bowel movements and bladder incontinence during a potential sexual interaction. In group educational sessions information is transmitted regarding male and female anatomy and physiology, and the effect of spinal cord injury on sexual response cycles, fertility and methods of contraception. Patients and family members may also be referred to books, articles and videotapes available in the patient library.

Specific Suggestions

A psychologist and a social worker meet regularly with a patient and spouse or significant other, if available, to evaluate in greater detail their personal strengths, their level of adjustment to the disability and the viability of the relationship. As part of the psychosocial evaluation, a premorbid sexual history of both partners may be obtained. This is of special importance because recently published findings indicate that 40% of healthy men and 63% of healthy women who are happily married suffer from erectile or orgasmic dysfunction.[6] Private and group counseling sessions are designed to broaden attitudes regarding the scope of sexuality, decrease anxiety about performance and increase ability to communicate effectively about sexual issues. Topics such as self-stimulation, fantasy and sexual myths about able-bodied and disabled men and women are discussed. Sexually explicit movies may be used to provide further material for discussion. Previously discharged male and female spinal cord-injured patients are invited to the group sessions and act as peer counselors. Specific suggestions that emerge may be as concrete as to empty the bladder before sex play to decrease anxiety over bladder incontinence, to adjust the timing of antispasticity medications if they seem to impede erections or to use assertive communication skills in social and sexual interactions.

Intensive Therapy

Intensive therapy is individually designed for each patient or couple by the psychologist and physician who work in close cooperation and on occasion as a co-therapy team. Individual and, if appropriate, couple exercises are assigned to be carried out in the Activities of Daily Living Apartment or at home while on leave from hospital. Sensate-focus exercises serve to increase awareness of one's own sexual responses and to alleviate performance concerns. Exercises also help to structure time to focus on resolving sexual problems and to promote new forms of verbal and nonverbal communication. For those patients without a sexual partner, individual sensate-focus exercises and social skills training exercises may be assigned. These patients are given opportunities to try out social skills on recreational trips away from hospital. Patients or couples return on a regular basis to counselors to review experiences, to explore their emotional reactions and to receive new assignments.

Report of a Case

The sexual rehabilitation process is exemplified by the case of a 21-year-old man who suffered a C5-6 fracture dislocation in an automobile accident. He immediately became quadriplegic and had complete loss of strength and partial sensory sparing below C6. At the time of admission to Casa Colina Hospital for Rehabilitative Medicine several weeks after injury, sacral sensation was present but diminished, voluntary anal sphincter control was absent and bulbocavernous and anocutaneous reflexes were hypoactive. The patient indicated that he had genital sensation and had experienced erection when his external catheter was applied. He related that he had asked his neurosurgeon regarding his prognosis and had been told that he would never be able to have sex again. The patient was then informed that many spinal cord-injured men are able to have satisfying sexual relationships. He was encouraged

to get to know his body as it now is and to explore it in terms of areas of pleasant sensation, diminished sensation, dysesthesia and absent sensation.

About two weeks after admission, the patient met with his physiatrist (J.B.M.) to discuss aspects of his management. He described his experiences with self-exploration since being admitted to hospital. He was further informed and reassured regarding the sexual capacities of spinal cord-injured men. He was eager to further explore his sexual capacities.

A meeting was then held with the young woman with whom the patient was intending to live following discharge. She wanted very much to spend the night with him. She felt that she was in love with him, but feared that if things did not work out sexually, the relationship would be doomed. She was given basic information, reassurance regarding the normalcy of her concerns and permission to take care of her own needs as well as his.

Six weeks into the rehabilitation program, the couple stayed overnight in the Activities of Daily Living Apartment. Afterwards the patient reported that he had been preoccupied with when to remove his external catheter and how often to put it back on. He was pleased that he did not wet the bed, had no involuntary bowel movements and remembered to turn so as to prevent decubitus ulcers. His partner had been worried about losing the spontaneity of sex and concerned that having to assist the patient physically would detract from the romance of the moment. Nonetheless, she experienced orgasm for the first time in her life, following oral stimulation by the patient. They also had successful intercourse but without ejaculation or orgasm for him. After several more sessions in the Activities of Daily Living Apartment, the patient was reporting occasional orgasm and ejaculation. His ability to feel sensations in his genital area was much less intense than before the accident, but his erections lasted indefinitely, as long as stimulation continued. After ejaculation, continued stimulation led to several orgasms in a row. His partner was elated because she was now regularly orgasmic with the patient. They had some questions about their prospects for having a child and a semen analysis was recommended.

After 18 weeks the patient was ready for discharge. He had reached his goals in mobility, self-care, bowel and bladder management, and psychological and vocational rehabilitation.

Since discharge about a year ago, the couple has been seen several times in follow-up. They are both working and they continue to have a good sexual relationship. They feel that the opportunities they had for sexual exploration during his hospital stay strengthened their relationship and contributed to his overall positive attitude about himself and to his success in the total rehabilitation program.

Discussion

It was not until the decade of the 1970s that significant attention was paid to sexual rehabilitation for patients with physical disabilities. This occurred despite findings that spinal cord-injured patients who were sexually dysfunctional also lacked motivation for vocational rehabilitation,[7] an impression that patients who avoid dealing with their sexuality also avoid realistic acceptance of their disability[8] and data that sexual problems rank high in importance for many spinal cord-injured patients.[9]

Since the 1970s there has been a blossoming of sex education and counseling programs,[10-14] but there continues to exist a subtle and sometimes overt belief that sex therapy is for "old" cord-injured patients. The myth is that recently injured patients are not ready for sexual rehabilitation. Certainly Maslow's hierachy of needs[15] would suggest that concerns for survival are more basic than a concern for sexuality; once the life and death issues are settled, however, and a patient is sufficiently medically stable for comprehensive rehabilitation, we believe he or she may also be ready to deal with sexual issues. We ascribe to cognitive social learning theory ideas that suggest that the expectancies and beliefs held by authority and staff will significantly affect the beliefs of persons living in the environment. Acute spinal cord-injured patients will rarely be comfortable addressing the issue of their sexuality as long as the milieu they live in is uncomfortable about this topic or believes it is too early to address it. We agree with Griffith and Trieschmann[16] that early active intervention and the availability of a private area within hospital for sexual exploration are highly beneficial.

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